EXPRESS SCRIPTS
Charting the Future of Pharmacy

Public Employees Insurance Agency

Medicare COB Drug Claim Form
West Virginia Public Employees Insurance

DIV WVA

Cardholder's Name (last, first, MI)	Date Of Birth	Gender M☐ F☐	Cardholder ID Number

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor.

Provider's Signature Date

Patient Information (one form is required for each patient)

1	Patient's Name	Patient's Address	Gender (circle) M☐ F☐	Date of Birth	How many prescriptions attached?
Provider Name and Address			Physician Name (name of prescribing Doctor) and DEA#:		

Prescription Information

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit.)

1. Print Cardholder's name (last, first, middle initial)
2. Print Cardholder's date of birth
3. Circle the correct letter to indicate if Cardholder is male or female
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card)

IMPORTANT: CLAIM FORM MUST BE SIGNED.
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED

Prescription Information Each submission must include:
1) *Medicare EOB*, 2) *Universal Claim Form* (UCF) **or** *Prescription receipts/labels* **or** a *Patient History Printout* from your pharmacy, **signed** by the dispensing provider, which includes all information listed below:

- Provider name and address
- Date filled
- NDC number, drug name and strength
- Rx Number
- Primary Payer Amount
- Quantity
- Days Supply
- Member Coinsurance
- Patient's name
- Billed Amount

(Please note that Claims received missing any of the following information may be returned or payment may be denied.)

Please return this claim to: **Express Scripts, Inc.-WVA**
P.O. Box 390873
Bloomington, MN 55439-0873
ATTN: Claims Department